RP Date ID: Aug 25 2021 2nd ID CONFIRMED

Michael F. Abramsky, Ph.D.
DIPLOMATE AMERICAN BOARD OF PROFESSIONAL PSYCHOLOGY

Ryan Fishman. 4-30-21 Intake:

DOB: [redacted]

Mr. Fishman was referred by an x-patient.

[redacted]

Diagnosis is "adjustment disorder with Anxiety. There is no Axis II Diagnosis, no premorbid vulnerabilities. [redacted]

[redacted]

Michael F. Abramsky PhD, ABPP
Licensed Clinical Psychologist
Diplomate in Clinical Psychology.
Diplomate in Forensic Psychology.

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PHONE: 248644.7398
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File No. 81720

Guardian

BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA
Main Only: Claims Service and Solutions Group
PO Box 981593, El Paso, TX 79998-1593
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Psychiatric Physician's Statement | Questions regarding this form? Call Toll Free 1-888-275-7473

To the Physician: Please provide answers to the questions below to support our evaluation of your patient's claim for disability benefits.

Patient's Name	File No.	Date of Birth
Ryan Fishman	81720	10-24-82

Patients Chief Complaint(s):

Date of First Visit: 4-30-21 Date of most recent visit: 8-5-21 Date of Next Visit: 8-12-21

Diagnosis(es):	ICD-10 / DSM-V Code(s):
1. 309. (DSM) Adjustment Disorder with anxiety	
2.	
3.	

Do you believe you have a sufficient understanding of this patient's occupation(s) and job duties to comment on their functional ability to work? ☑ Yes ☐ No

If yes, what is your understanding of this patient's occupation(s) and job duties? Pt is a practicing attorney, administrator of a collection practice

Are you advising this patient to:

a) Restrict or limit work activities? ☐ Yes ☐ No If yes, as of what date? ___/___/___
If yes, what aspects of this patient's job duties are they restricted or limited from performing?

b) Stop working altogether? ☑ Yes ☐ No If yes, as of what date? ___/___/___
If yes, what aspects of this patient's job duties are they unable to perform?

What is the patient's anticipated time frame for return to work?

Unknown

[redacted]

[redacted]

benefits.

Michael F Ablamsky	Clinical Psychology
Physician Name (please print):	Medical Specialty(ies):
Office Telephone No.: 248-644-7398	Office Fax No.: none
ablamskymf@gmail.com	
Office Address, City or Town, State or Province, Zip Code: 954 Cantaberry, Birmingham, MI 48009	
Physician Signature:	Date: 8-5-21

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Does this patient have a history of a psychiatric condition? ☐ Yes ☒ No

Does this patient have a history of substance abuse? ☐ Yes ☒ No

Specify current treatment plan / type of treatment (i.e., CBT, DBT, EMDR, Medication Management, IOP, Frequency of Visits, etc.):

Weekly Psychotherapy, including meditation practice and general health monitoring; exercise, diet

Current medications (include dosage, frequency and last date of change):

Treatment goals: Resolve Anxiety, return to functioning

Does the treatment plan include return to work goals? ☒ Yes ☐ No Please explain:

Is this patient compliant with your recommended treatment? ☒ Yes ☐ No

Have you discussed your treatment plan and return to work goals with this patient? ☒ Yes ☐ No

Is this patient in agreement with the treatment plan? ☑ Yes ☐ No

Test results or other rating scale score (please specify test, scale, measure used, and date):

No testing

Objective observations of this patient's behaviors, affect, mood: Mood is anxious, pt exhibits of depression. Concentration, attention significantly compromised

Subjective complaints reported by this patient (include frequency, severity, duration): Distractable, obsessive, Frightened, worried, despondent

Is this patient treating with any other provider(s)? ☐ Yes ☐ No
If yes, please include name and specialty:

Are you coordinating care with this provider(s)? ☐ Yes ☐ No If yes, last date of contact:

How would you rate this patient's current degree of psychiatric impairment?

☐ I do not have sufficient information to make a reasonable assessment.
☐ Essentially good functioning in all areas. Occupationally and socially effective.
☐ Moderate impairment in occupational functioning. Limited in performing some, but not all, occupational duties. Able to maintain meaningful interpersonal relationships.
☐ Major impairment in several areas, e.g., work, family relations. Avoidant behaviors, neglects family, unable to work.

Do you believe this patient is competent to endorse checks and direct the use of the proceeds? ☑ Yes ☐ No
If no, as of: 8 / 5 / 21

Do you believe this patient is competent to execute a Power of Attorney? ☑ Yes ☐ No If no, as of: ___/___/___

Have you completed disability claim forms on behalf of this patient for other insurance carriers? ☐ Yes ☑ No
If yes, please provide the name of the company(ies):

Are you related to this patient by blood or marriage, or are you a member of this patient's household? ☐ Yes ☑ No

Are you this patient's business partner, professional partner, employer, or a person who has a financial affiliation or business interest with this patient? ☐ Yes ☐ No

Our goal is to understand the extent to which your patient is restricted or limited by the chief complaints outlined above. If we have additional questions after reviewing this form, a claim professional or clinical consultant may contact you.

What is a convenient day and time for us to call? Tues - Friday 9 - 5

What telephone number would you like us to use? 248- 644- 7398

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially, false information, or conceals for purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.

Physician Name (please print): Michael F Abramsky	Medical Specialty(ies): Clinical Psychology
Office Telephone No.: 248- 644- 7398	Office Fax No.: abramskymf @ gmail.com
Office Address, City or Town, State or Province, Zip Code: 954 Canterbury, Birmingham, MI 48009	
Physician Signature: [signature]	Date: 8-5-21